

For use by health professionals as a baseline health assessment.

In conducting this assessment you should be aware of the FOM guidelines related to the management of low back pain at work (Faculty of Medicine. Occupational Health Guidelines for the Management of Low Back Pain at Work. Evidence Review and Recommendations. Faculty of Medicine, London 2000 ISBN 1860161316)

Baseline Assessment

Date of assessment:

Name

D.O.B.

Gender

Job

Employee No./Works reference

GENERAL INFORMATION

Weight _____

Height _____

Body Mass Index (BMI) _____

Do you currently smoke?

YES: How many _____ For how long have you smoked _____ years

NO: If stopped when did you give up? _____ years ago

Do you regularly exercise? **YES/NO**

If 'yes' what do you do and how often:

Females only

Are you pregnant or have you had a baby in the last 6 months? **YES/NO**

OCCUPATIONAL HISTORY

(1) _____ for _____ years.

What percentage of job involved driving _____ %

Type of vehicle _____

Any Manual Handling involved? **YES/NO**

(2) _____ for _____ years. Did this involve driving?

What percentage of job involved driving _____ %

Type of vehicle _____

Any Manual Handling involved? **YES/NO**

(3) _____ for _____ years. Did this involve driving?

What percentage of job involved driving _____ %

Type of vehicle _____

Any Manual Handling involved? **YES/NO**

Use of any other vibrating equipment/machinery in last 3 years?

YES: Describe

NO

Other leisure exposures to vibration (much leisure driving or driving hobbies?)

YES: Describe

NO

PAST MEDICAL HISTORY

Have you ever had back pain which has resulted in time off from work?

YES/NO

Have you ever had ANY previous trauma to the back/neck/shoulder, which has required the intervention of a doctor or physiotherapist?

YES (refer to further health questions*)

NO

Has a doctor ever told you there is something wrong with your back (a medical diagnosis)? e.g. disk herniation/protrusion, spinal stenosis, facet syndrome, spondylosis, spondylolisthesis, nerve root syndrome

YES: (refer to further health questions*) What?

NO

Have you ever had an operation on the back?

YES/NO

Have you ever been involved in an RTA?

YES/NO

Any other musculoskeletal problems/complaints in the past?

YES/NO

RECENT EXPERIENCE

Is there currently any movement or activity that causes you pain in your back/neck/shoulder?

YES: Describe

NO

Have you suffered any back/neck/shoulder pain in the last 12 months?

YES: Describe

NO

Has this back/neck/shoulder pain kept you from your usual activities?

YES/NO

Have you had to take any medication to deal with the pain experienced?

YES (refer to further health questions*)

NO

Have you had to seek medical advice regarding this pain?

YES (refer to further health questions)*

NO

Are you aware of any factors which may have contributed to this pain?

YES: Describe

NO

ACTION/ADVICE

Risk factors identified =

Advice given to the individual =

Further advice to be obtained =

Fitness for work?

Question on any hobbies or leisure activities which may have caused, contributed to or aggravated symptoms

ACTION TAKEN

Referral for further medical advice?

Review of work activities?

Change in work activities?